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To: Mitzi D. Paige
Assistant U.S. Attorney

Feb. 7, 2012

Submitted for review are standard radiograph series of the Left femur, Left knee, and Pelvis/left hip on Brandon E. Phillips dated April 7, 2007 at 23:49 from MS Band of Choctaw Hospital Radiology Dept. The stated history at the time of interpretation was " *Injured while playing basketball 5 days ago, pain, unable to ambulate*". The official "draft" dictation is signed by R. Christian, MD apparently on or about April 9, 2007 at 15:13. My opinion of these radiographs is that they are all normal. The "*suspected Left lesser tuberosity avulsion fracture*" reported by Dr Christian is felt to be normal variant anatomical appearance in a patient of this age. Rotated positioning of the patient accounts for the apparent asymmetry of the hips. No fracture is seen. No lytic or blastic osseous lesions are present and overall skeletal framework is normal. Soft tissues appear normal by radiographs without indwelling gas or foreign bodies. There is no evidence of trauma or infection. This is a normal radiograph. The images of the knee and femur likewise are normal.

A CT scan of the pelvis dated 4/7/2007 on the same patient is submitted for my evaluation. The exam consists of seventy six 3mm noncontrast images of the pelvis submitted in both soft tissue and bone windows. Additionally a single frontal scout image was acquired as is typically the case. No sagittal or coronal reformat images were made available to me. The preliminary report by Jeffery J. Zatorski MD of Horizon Radiology dated 4/7/2007 at 5:01pm states " *Fluid adjacent to the left greater trochanter may represent bursitis or possible tear. Recommend MRI. No definite fracture.*" and the history on the request received by Dr Zatorski appears to be "*injured left pelvis/hip; unable to walk*". I agree with this preliminary radiology report which was apparently made via teleradiology by an afterhours/call coverage service (Horizon Radiology). Brief limited reports such as this is standard protocol for preliminary scan interpretations performed on call/afterhours.

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Follow up "draft" dictation dated April 9, 2007 by Dr Christian concerning the same CT scan mentions "*asymmetry of the intramuscular soft tissues adjacent to the greater trochanter of the femur on the left side probably representing a muscular tear with resultant intramuscular hematoma. The study is otherwise unremarkable.*" Additionally it is mentioned that the previously suspected (by radiographs) "*lesser trochanteric avulsion fracture is probably normal*".

My personal review of this CT scan is concordant with the above radiological interpretations. There is indeed asymmetry of the fat planes from hip to hip but with no underlying fracture. There are mild inflammatory changes in the soft tissues overlying the Left greater trochanter with a 13mm x 38mm area of inflammatory fluid density in this region. This is located in the anterolateral most aspect of the left gluteus medius muscle belly at its junction with the gluteus maximus muscle. Mild strandy changes are located in the overlying subcutaneous fat as is typically seen due to inflammation from any source, be it infection, post traumatic sequelae (muscle/tendon tear or direct contusion), or other sterile inflammatory response. No gas or foreign bodies are present and there is no CT evidence of penetrating trauma. Underlying bones are entirely normal given the patients age. Growth plates are open and symmetric. No lytic or blastic lesions are present. No erosions or cortical irregularity is present to suggest osseous infection (osteomyelitis). Additionally the hip joint spaces themselves are symmetric with no widening of the left hip joint as can be seen in the setting of a septic hip. No joint effusion is appreciated as one expects to see in the setting of a septic joint. The above described inflammatory changes and fluid are quite superficial relative to the hip joint proper and its location as well as the overall appearance is much more compatible with trochanteric centered pathology such as a tendon or muscle tear with associated hematoma. This is especially true given the stated patient history. While bursitis could yield this appearance there is nothing on this scan that is definitive evidence of an infectious process. The scan is most compatible with post traumatic sequelae and no convincing emergent findings are present. Both the preliminary and final CT scan reports are accurate and complete.

My medical training consists of obtaining an MD from University of MS School of Medicine followed by 1 year of internship at Baptist Hospital in Memphis, TN. Afterwards I spent 4 years in Diagnostic Radiology residency at Parkland Hospital/ U. of TX at Southwestern in Dallas.

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I subsequently completed an additional year of Musculoskeletal fellowship at the same institution. I have been in private practice for greater than 7 years now in Jackson, MS with a large part of my daily work consisting of musculoskeletal imaging (radiographs/Xrays, MRI, nuclear medicine, and CT scans). This is my first time as an expert witness. My CV is attached.

I charge $350/hour for record review and report preparation, $350/hour for preparation for testimony, and $500/hour for deposition and court testimony.

Sincerely,

Robert Houston Hardin, Jr MD